Testimony on

Medicare Advantage

By

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I. Introduction

Mr. Chairman, Representative Ryan, and members of the committee, my name is Catherine Schmitt and I am Vice President of Federal Programs at Blue Cross and Blue Shield of Michigan. I appreciate this opportunity to testify on the Medicare Advantage program.

Blue Cross and Blue Shield of Michigan (BCBSM) is a non-profit health plan that serves nearly five million members, of which 440,000 are enrolled in government contracted Medicare or supplemental programs. Nearly 70 years ago, Blue Cross Blue Shield of Michigan started with a purpose to provide people with the security of knowing they have health care when they need it. Today, we're accomplishing that mission in many ways, including offering access to health care coverage for everyone, regardless of circumstances, as the insurer of last resort.

Blue Cross Blue Shield of Michigan is committed to offering Medicare products that meet the needs of the individual members, employers and unions that we serve. We offer a range of plans to Medicare beneficiaries in every county of the State of Michigan, including Medicare Advantage (MA) Private Fee-For-Service (PFFS) plans, Medicare Part D coverage, and supplemental coverage. The BCBSM enterprise also offers a MA HMO product in counties where an adequate network could be developed. Our Medicare Advantage plans play an important role in providing comprehensive, coordinated benefits for seniors and disabled members who might not otherwise have affordable options for supplemental benefits.

In my testimony today, I will provide an overview of the importance of Medicare Advantage with a primary focus on the role of the PFFS plan in meeting the needs of Medicare eligible beneficiaries who are retirees of employers and unions. We believe that it is critical to preserve the PFFS option because it is the only product available today for bringing integrated health benefits to the retirees of employers and unions nationwide under Medicare Advantage.

II. Why did BCBSM offer a Private Fee-For-Service Plan?

BCBSM has traditionally served the Medicare population through Medicare supplemental plans, or Medigap. However, with the passage of the Medicare Modernization Act (MMA), which addressed inadequate payment levels in Michigan that had made Medicare+Choice plans unsustainable, we saw an opportunity to make comprehensive coverage through Medicare Advantage and Part D plans available to our customers.

We chose the private fee-for-service plan for a number of reasons. In the individual market, we needed a less costly alternative to Medigap, which had become too expensive for many of our customers. Even with a dedicated contracting team, network health plans take years to develop as health care providers will not contract initially for the Medicare allowable amounts. They want higher payments and re-contracting would have taken considerable lead time. So, we found ourselves with Medicare members who have been with Blue Cross and Blue Shield their whole life and we wanted to continue to serve them if they were interested in Medicare Advantage.

At the same time, employers were asking for alternatives to their current arrangements which supplement Medicare but do not coordinate care or focus on health improvement. Our employer and union customers needed a solution for serving retirees all over the country and using a state-wide PPO would leave no choices for the group with retirees residing in different parts of the country like Arizona, California, Florida and New Mexico. Due to a combination of regulations that prevent PPOs and HMOs from offering coverage to retirees outside of their state and the lack of nationwide acceptance by providers to participate in networks for Medicare Advantage products, PFFS is the only option available for serving these members.

Medicare Advantage private fee-for-service plans allow our employers to provide retiree health care plans identical to the benefit programs they offer active and non-Medicare eligible retirees nationwide incorporating the same care management features such as care coordination and disease management programs through a single Plan, eliminating the need to stitch together multiple HMOs or PPOs that would cover only a portion of their retirees nationwide.

I would like to share with you an example of our largest group account enrolled in PFFS and explain why this coverage is so valuable to them. The Michigan Public School Employees Retirement System (MPSERS) implemented a Medicare Part D Prescription Drug Plan in 2006 and a Medicare Advantage private fee-for-service plan in 2007 in order to lower health care costs and improve health care management and outcomes for their Medicare eligible retirees.

There are more than 115,000 MPSERS members in the Medicare Advantage private fee-for-service plan. Many include lower-income retired clerical staff, bus drivers, janitors and cafeteria workers. Medicare Advantage provided MPSERS with an opportunity to reduce the System's cost and integrate coordinated medical and drug management programs. This option also allows them to manage health care costs without reducing school programs for the students.

III. The Importance of Maintaining Medicare Advantage

I would like to stress three reasons why it is important for Congress to maintain funding for the Medicare Advantage program and preserve the private fee-for-service product: enhanced benefits and cost savings for beneficiaries, opportunities for care coordination, and providing access in rural areas.

Enhanced Benefits and Cost Savings for Beneficiaries

Medicare Advantage plans provide beneficiaries with substantial protection from the high cost-sharing in traditional Medicare plus additional benefits not offered under Medicare. According to CMS, Medicare beneficiaries receive an average additional value of $86 per month – or $1,032 per year -- from enrolling in an MA Plan. The majority of that value comes from reduced out-of pocket costs because plans generally fill deductibles and co-payments in original Medicare and provide protection against catastrophic costs.

Our PFFS plans offer members benefits that are more generous than Medicare alone, especially in the group market. We estimate that the value of benefits offered among our plans is 21-33

percent more generous than original Medicare. This is because our employer and union accounts generally want to offer their retirees the same benefits they provide to their active workers and are willing to subsidize the group product. We also offer individual products with an actuarial value of up to 27 percent more than traditional Medicare.

Our lowest cost plan (with premiums of $0-$61 per month depending on one's area) offers a number of additional benefits not available in traditional Medicare. This plan has an annual out-of-pocket limit of $5,000 that offers the peace of mind that an unexpected illness won't result in bankruptcy. This is a benefit that is not available in traditional Medicare as FFS cost sharing on one significant hospital or skilled nursing admission can easily exceed $5000. Our plan has a $20 copay for doctor visits instead of the 20% coinsurance in FFS Medicare. In order to foster good preventive care, our plan has no cost sharing for services such as bone mass measurement, mammograms, prostate and colorectal cancer screenings and immunizations**.** We also provide much more generous benefits for inpatient and outpatient mental health care.

Another advantage is that MA plans have flexibility to offer innovative benefits that are not permitted under the Medicare program and that better meet the needs and preferences of beneficiaries. For example, we can offer the member the option of obtaining care in the setting of their choice following a hospitalization, when traditional Medicare might only have provided the payment for care in a skilled nursing facility.

All of our individual plans are comprehensive MA-PD plans and groups can select either an MA-PD plan or an MA plan with the Retiree Drug Subsidy. In either case, we can provide comprehensive, fully integrated programs. Additionally, members like the fact that, as Medicare Advantage members, they can continue to carry a single Blue card for their Medicare A and B benefits, supplemental and drug coverage.

If Congress cuts MA funding, plans will be forced to increase cost-sharing for these services, cut benefits, or increase premiums. This will most affect those seniors who are living on lower-to-modest incomes who may lack affordable alternatives. The average premium for Medigap Plan C in Michigan is $2,355 annually (or nearly $200 a month) and the average premium for

Medigap Plan C nationally is $1,766 annually (nearly $150 a month). These premiums may be out of the reach of many seniors who have purchased Medicare Advantage products.

Care Coordination

Medicare Advantage holds promise for meeting one of the biggest challenges facing Medicare: coordinating care for those with chronic illnesses. Today, 82% of Medicare beneficiaries have at least one chronic condition, with 65% having multiple chronic conditions. However, according to a report by the Institute of Medicine, FFS Medicare does little to encourage coordinated, preventive and primary care that could produce better outcomes for beneficiaries.

Medicare Advantage plans can play a critical role in addressing this challenge through offering care coordination and management for diseases that commonly afflict the elderly through an integrated benefit package. Employers are turning to our PFFS product because they can provide the same care coordination programs that are available to their active and non-Medicare eligible retirees. The importance of the integrated benefits available under Medicare Advantage plans cannot be understated. With a Medicare supplemental plan, inadequate and untimely claim information does not allow for meaningful coordination. By the time information is received, it may be too long after a major event to reach out to a member, their family or providers.

Our Medicare Advantage members benefit from a variety of voluntary, patient-centered programs designed to improve their health through our BlueHealthConnection® program. BlueHealthConnection provides a spectrum of wellness, disease and symptom management, and case management opportunities for PFFS Medicare Advantage beneficiaries to take an active role in improving their health.

For example, we provide access to personal health care coaches to assist members in the management of chronic conditions, such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disorder, cancer, benign uterine conditions, and back pain. The program is focused on building self-reliance and seeks to inform members by

providing a range of information, transferring skills, building confidence, and enabling members to take action to improve their health.

We also provide access to a case management program that focuses on members with multiple co-morbidities, those who are the most difficult to care for. These initiatives provide telephonic and face-to-face assessments, develop collaborative care plans with both physicians and members, and use evidence-based guidelines to measure success. Through this program, we also provide telemonitoring devices to assist health care professionals in the management of complex conditions, such as congestive heart failure.

We believe that programs offered by the plan a member has selected, such as BCBSM, and is familiar with, will be far more successful than efforts by other third-party companies contracted by CMS where the beneficiary does not know or trust the party contacting them about their health care needs.

Access for Rural Beneficiaries

Historically, the existence of private plan options in rural America has been virtually non-existent with the benefits of private plans only available to beneficiaries in urban cities. Congress sought to reverse this trend by raising rates in rural areas over the past decade. The intent was to increase payments so plans could operate more viably in rural America so that all Medicare beneficiaries would have access to a private plan option.

Network-based products are difficult to construct in rural areas with sparse populations and limited provider availability. In rural areas of the country, where traditional Medicare rates are very low, providers often refuse to join a plan's network unless reimbursement from the plan far exceeds what the Medicare rate would be. Unless plans can meet the network adequacy requirements of CMS, they will not be approved to participate in the MA program.

Due to the availability of PFFS plans in 2007, for the first time all Medicare beneficiaries in the country have the choice of a private Medicare plan option: a significant increase from 2004 when

one-quarter of beneficiaries did not have that option. Between 2005 and 2006, enrollment in PFFS plans by rural beneficiaries accounted for 39 percent of total MA enrollment growth.

If Congress equalizes MA and traditional Medicare payments, this would have a disproportionate impact on rural areas by eliminating the increased payments in rural areas. Some rural states would have no access to MA options at all if these cuts were enacted.

IV. Responding to Criticisms of Medicare Advantage Plans

A number of criticisms have been raised regarding the Medicare Advantage program over the last few months. I would like to respond to several of the issues you may hear today.

- ***Comprehensiveness of coverage relative to traditional Medicare.*** Some have argued that MA plans modify benefits in traditional Medicare and create financial barriers for high cost beneficiaries. We use the flexibility we have to tailor our plans to meet the preferences of our members for predictable cost-sharing, protection from catastrophic expenses, and benefits not covered under FFS Medicare. MA plans return an additional $6.8 billion dollars in supplemental benefits, according to CMS. Those who consume more services will generally benefit more from the financial protections in our MA plans.

  A recent analysis published in *Health Affairs* found that the average out-of-pocket cost for all MA plans was $268 (Gold, 2007). Average out-of-pocket costs for members in poor health were estimated at $1,656 for all MA plans. The Blue Cross and Blue Shield Association applied the same methodology to spending under traditional Medicare with prescription drug plan coverage and found the costs for those in poor health was $5,408 – more than three times the estimate for all MA plans in the *Health Affairs* article.

  While it may be theoretically possible to choose selected services for which an individual could pay more under an MA plan, this would generally not be the case if one looked at the total distribution of claims for an individual over an entire year that includes all doctor,

hospital and other services. Thus, I would caution against looking at outliers and focus instead on the vast majority of beneficiaries who see better value under MA.

- ***Specific issues with private fee-for-service plans.*** Over the past couple of months, a number of criticisms have been leveled against PFFS plans. Some of these concerns involve legitimate issues that industry and regulators are working to address to ensure confidence in this product. My message is simple: let's stop vilifying PFFS plans and instead focus on correcting the legitimate issues and improving the program.

  The most troubling concerns leveled against PFFS plans involve instances of unscrupulous and even fraudulent sales tactics involving sales of individual PFFS plans. Some of the incidents were appalling and should never have happened. CMS has acted decisively to strengthen enforcement of marketing standards to address these problems. We continue to strengthen our agent training requirements and have a zero tolerance policy for agents that do not follow the rules. Our complaint ratio regarding agents is less than 1 for every 2,000 enrollees. It is important to note that these sales problems simply are not an issue with employer and union accounts. Group PFFS products do not involve the use of agents or brokers for individual sales to their members. Employers and unions work with us to ensure that retirees understand these products.

  Some have questioned the value of PFFS plans, given the exemptions that they have from certain requirements that apply to Medicare HMOs and PPOs. Some of the current PFFS exemptions make sense, given the very different nature of PFFS plans as compared to HMO and PPO plans. However, we recommend ending three exemptions to inject more accountability and provide increased value to beneficiaries. We should require PFFS plans to report quality data, establish chronic care improvement programs (which would remain voluntary on the part of beneficiaries), and allow CMS to review PFFS bids.

  Some have also raised questions about provider acceptance of PFFS plans. The PFFS product is unique in that it does not require use of a defined network of providers like a PPO

or HMO. While this enables us to serve retirees in every area of the country, it also means that there is no guarantee that a given provider will see a patient. Our rate of provider acceptance is very high. We respond to these incidents by working to educate providers on the benefits of participation, including receipt of a single payment from the health plan for all services rather than waiting for transfer, processing and payment of the supplemental claim after the Medicare claim is paid. We have found that physician offices we contact almost always decide to accept our PFFS patients once they understand our products. When a provider still refuses to participate, we make every effort to locate an alternative provider for the member.

- ***Risk selection in MA and the traditional program.*** Some have suggested that MA plans are eroding the risk pool in traditional Medicare by attracting healthier seniors through benefit design. While there may have been some evidence of this in the early years of this program, the reality today is that health plan enrollees have similar health status to the overall Medicare population. MA payments are also fully risk adjusted which removes any incentive to enroll healthy beneficiaries. Risk adjustment pays plans more for enrolling sicker individuals and less for healthy ones, providing an incentive to enroll the sickest beneficiaries and manage their care appropriately. Moreover, there is significant growth in MA Special Needs Plans that are specifically designed to allow a plan to enroll those who are institutionalized or have specific chronic conditions. These tend to be the sickest and most costly beneficiaries in Medicare.

- **Arguments that MA plans are "overpaid".** One concern leveled at MA plans is that their average payments are 12% more than claims costs under traditional Medicare (19% more for PFFS plans) according to MedPAC. In reality, comparing MA and FFS costs is an apples to oranges comparison that fails to take into account the significant differences between the two programs. Traditional Medicare pays claims for an uncoordinated package of benefits that includes high beneficiary cost-sharing. Medicare Advantage plans provide a more comprehensive package of benefits with care coordination, disease management, quality accountability, and usually with integrated drug coverage.

The question that continues to go unanswered in the current Congressional debate is what type of Medicare program do we want over the long-term? On an industry-wide basis, there is a clear movement toward more integration and coordination of care in order to improve quality and member health outcomes. Yet every time the federal government invests in these programs for Medicare in a meaningful way the funding is threatened.

Congress has already cut MA base funding by $6.5 billion in the Deficit Reduction Act (cuts that will be phased in through 2010). This is having an impact on our payments in Michigan, which are rising at a rate that is below growth in medical costs, which over time will result in increased year-to-year costs or reduced benefits for our members.

This is exactly what happened in the years prior to the MMA, when Medicare+Choice became unsustainable in many counties after years of medical cost increases outstripped growth in plan payments. The result was widespread loss of coverage for Medicare beneficiaries. Congress should not backtrack on its promise of broader access to health plan options for beneficiaries.

If Congress adopts MedPAC's recommendations for cutting MA funding, the PFFS product is unlikely to be viable in many states. The result may well be that most, if not all, of the 1.3 million enrollees in this product will lose access to the enhanced benefits and opportunities for care coordination that come with these products. According to a study by Professors Ken Thorpe and Adam Atherly at Emory University, adopting MedPAC's recommendations could result in 3 million people losing their MA coverage, including more than 180,000 in Michigan.

What would the loss of the PFFS option mean for Michigan? It will mean that many Medicare beneficiaries who make too much to qualify for Medicaid, but cannot afford a Medigap policy, will be left without an option for obtaining affordable supplemental coverage. It will mean the loss of care coordination and health improvement opportunities. It will mean that employers and unions struggling to maintain retiree benefits in light of new

accounting rules will be forced to make hard choices about reducing or even eliminating retiree benefits. It will mean more confusion for beneficiaries who will lose trust in Congress, CMS and plan sponsors.

V. Conclusion

Thank you for considering my perspectives on the Medicare Advantage program. I appreciate this opportunity to testify about the importance of the private fee-for-service product. Medicare beneficiaries need stable options for supplemental benefits and PFFS plans are a major source of that coverage in many areas of the country. We urge the committee to ensure the continued viability of this product and to support adequate funding for the Medicare Advantage program.